Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRESBYTERIAN PLANO CENTER FOR
DIAGNOSTICS & SURGERY
P O BOX 676266
DALLAS TX 75267

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-06-2782-01

MFDR Date Received
DECEMBER 19, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PRE-AUTHORIZED SERVICE"

Amount in Dispute: $103,173.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office will maintain its denial for 057 and 47, as PLN 11 attached."

Response Submitted by: State Office of Risk Management, P. O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2005 Through June 16, 2005	Inpatient Hospital Services	$103,173.77	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes listed as the primary diagnosis reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for servicers not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guideline may not provide for payment of a fee in excess of the fee charges for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- D19 – Claim/Service missing supporting documents
- 18 – Duplicate Claim/Service
- R1 – Duplicate Billing
- 178 – Treatment inappropriate for stage of injury
- W4 – No additional payment allowed after review
- W12 – Extent of Injury, Not finally adjudicated.
- 074 – Denied per IME
- 057 – ICD-9 Code Unrelated to Reported Injury Claim
- 47 – Diagnosis is not Covered
- 106 – Provide invoice showing cost for reimbursement

Issues

1. Has the extent of injury issue been adjudicated?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The services in dispute were denied, in part, due to an unresolved extent of injury issue. The disputed issue involved whether the compensable injury extends to a fractured lumbar vertebrae. A Benefit Review Conference was held on April 18, 2006 to mediate a resolution of the disputed issue. An agreement was reached in which the parties agreed that the compensable injury of August 25, 2004, **does not** include the fractured lumbar vertebrae. The division concludes that the extent of injury issue is resolved.
2. Review of the documentation submitted indicates that the provider billed for its services under diagnosis code 805.4 (Closed Fracture lumbar Vertebra w/o Spinal Cord Injury). The treatments in dispute were rendered for an injury which the parties agreed was not compensable according to the Benefit Review Conference Agreement of April 18, 2006 discussed above. The requestor rendered health care to this injured employee for the non-compensable fractured lumbar vertebrate; therefore, no reimbursement can be recommended for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		November 29, 2012
Signature	Director, Health Care Business Management	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.